Re-evaluation EIV

Analyst _____
Re-evaluation__
HIPP#

EMPLOYER INSURANCE VERIFICATION

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Health Insurance Premium Payment (HIPP) Program
600 E. Broad Street, 12th Floor
Richmond, VA 23219
(804) 225-4236/ (800) 432-5924 (in Virginia only)

The State of Virginia is considering providing the health insurance premium assistance on behalf of the employee below, in accordance with Section 1906 of the Social Security Act. Any information provided on the form will remain confidential. In order to make a determination, please complete and return this form within 15 days to the mailing address above. If you have questions in regards to completing the form, please contact us at the phone numbers listed above.

My signature serves as a release of information for verification of all required information.

Employee Name: _____ **Phone Number:**_____

Address: _____ **Signature:** _____

INFORMATION BELOW IS TO BE COMPLETED BY THE EMPLOYER ONLY

PART A – EMPLOYEE INFORMATION

Employee Name (Last, First, MI):	Full SSN: - -	(MM/DD/YY) Date of Birth: / /

1. Employee Status ☐ Full-Time ☐ Part-Time

Date Hired: _____

1a. Retired from previous employment? ☐ Yes ☐ No

2a. Is this employee eligible for coverage under your company's group health plan? ☐ Yes ☐ No

(If "No", reason:_____)

2b. Is employee currently enrolled in the Health Plan? ☐ Yes ☐ No

If yes, provide the Effective Date:_____

PART B – MEMBERSHIP (Starting with Employee) - *Attach an additional page if more than 7*

Name (Last, First MI)	Full SSN	Date of Birth	Relationship	Currently Enrolled in Plan	Eligible for Health Plan
	- -	/ /	Employee	☐ Yes ☐ No	☐ Yes ☐ No
	- -	/ /		☐ Yes ☐ No	☐ Yes ☐ No
	- -	/ /		☐ Yes ☐ No	☐ Yes ☐ No
	- -	/ /		☐ Yes ☐ No	☐ Yes ☐ No
	- -	/ /		☐ Yes ☐ No	☐ Yes ☐ No
	- -	/ /		☐ Yes ☐ No	☐ Yes ☐ No
	- -	/ /		☐ Yes ☐ No	☐ Yes ☐ No

PART C - COVERAGE

1a. If the employee is currently enrolled, what is the type of coverage? Select one of the following:

☐ Employee Only ☐ Employee + Child ☐ Family
☐ Employee + Spouse ☐ Employee + Children ☐ Other_____
☐ COBRA

OPEN-ENROLLMENT INFORMATION

1b. Effective Date (MM/DD/YY): _____ /_____/_____

Open Enrollment Dates

From:_____ To:_____

2. If the employee is not currently enrolled, when can enrollment occur?

☐ During Open Enrollment Dates: _____ ☐ After employment period is met - Date Eligible: _____
☐ Anytime

Re-evaluation EIV

Analyst _____
Re-evaluation__
HIPP#

PART D – PLAN BENEFITS (Please indicate the cost and benefits for the coverage the employee has elected or has available to select.)

Name and Address of Insurance Company:	(IF MULTIPLE PLANS) Name and Address of Insurance Company:
Insurance Company Phone: ( )	Insurance Company Phone: ( )
Insurance Policy/Group Number:	Insurance Policy/Group Number:
Does policy have an attached health savings account (HSA)? ☐ Yes ☐ No What are the yearly deductibles for the health insurance: Individual $ Family $	Does policy have an attached health savings account (HSA)? ☐ Yes ☐ No What are the yearly deductibles for the health insurance: Individual $ Family $

Premium Information (Employee's portion only)

Coverage	Premium	How Often
Employee Only	$	☐ Weekly ☐ Every 2 weeks: ☐ 24/year ☐ 26/year ☐ Semi-Monthly ☐ Monthly Other:_____
Employee + Spouse	$	
Employee + Child	$	
Employee + Children	$	
Family	$	
Other	$	

Premium Information (Employee's portion only)

Coverage	Premium	How Often
Employee Only	$	☐ Weekly ☐ Every 2 weeks: ☐ 24/year ☐ 26/year ☐ Semi-Monthly ☐ Monthly Other:_____
Employee + Spouse	$	
Employee + Child	$	
Employee + Children	$	
Family	$	
Other	$	

Type of Plan:	Services Covered:
☐ Comprehensive Major Medical	☐ Medical
☐ HMO/PPO	☐ Drugs
☐ Hospital Only	☐ Dental
☐ Dental	☐ Vision
☐ High Deductible Health Plan	
☐ Other (please explain):	

Type of Plan:	Services Covered:
☐ Comprehensive Major Medical	☐ Medical
☐ HMO/PPO	☐ Drugs
☐ Hospital Only	☐ Dental
☐ Dental	☐ Vision
☐ High Deductible Health Plan	
☐ Other (please explain):	

Please Note: **State regulations <u>require</u> that the information requested on this form be verified. Please provide the employer representative information for a HIPP analyst to contact.**

PART E – EMPLOYER'S REPRESENTATIVE

I hereby certify that all information contained herein is true and is correct to the best of my knowledge.

Human Resource Representative or Benefits Manager:	Department:
Employer/Company Name:	Work Phone: ( )

Employer Address:	City	State	Zip Code

Signature of Employer:	(MM/DD/YY) Date: